

Healthy Teeth = Healthy Kids

A plan to improve the oral health of Milwaukee children.



2007

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A plan to improve the oral health of Milwaukee children.

A community partnership created through a Healthier Wisconsin Partnership Program development grant awarded by the Medical College of Wisconsin.

The following key partners are responsible for guiding and creating this plan:

Children's Health Alliance of Wisconsin
Children's Hospital of Wisconsin Dental Center
Marquette University School of Dentistry
Medical College of Wisconsin
Milwaukee Public Schools

Acknowledgements

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Columbia St. Mary's Madre Angela Dental Clinic
Delta Dental of Wisconsin
Dental Hygiene Association of Wisconsin
Doral Dental USA
Greater Milwaukee Dental Association
Milwaukee Area Technical College
Milwaukee Health Services Inc.
Next Door Foundation
Sixteenth Street Community Health Center
Social Development Commission Head Start
Southeast Dental Associates
Westside Healthcare Association
Wisconsin Dental Association
Wisconsin Dental Hygiene Association
Wisconsin Department of Health and Family Services
Wisconsin Hospital Association

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Table of contents

Definitions and terms	2
Acronyms	3
Executive summary	4
Cause for concern	6
Process for development	8
Recommendations	11
Role of community	21
Conclusion	25
Appendices	26
A: Summary of focus group results	26
B: Model and budget for school-based oral health teams	29
C: Milwaukee Public Schools free and reduced lunch rates	30
D: Milwaukee County Medicaid pediatric dental providers	32
E: Inventory of current oral health services and programs serving children in Milwaukee	34
F: City of Milwaukee Medicaid utilization (2006).....	36
G: Fee schedule comparison	37

Definitions and terms

Definitions

Community stakeholders - Individual representatives of community organizations, associations and institutions who have an interest in oral health and provided input into this plan.

Key collaborators - individuals or organizations that will work together, and with community stakeholders, on one or more strategies within an objective.

Key partners - The five entities who partnered to apply for the Healthier Wisconsin Partnership Program (HWPP) development grant: Children's Health Alliance of Wisconsin (CHAW), Children's Hospital of Wisconsin (CHW) Dental Center, Marquette University School of Dentistry (MUSoD), Medical College of Wisconsin (MCW) and Milwaukee Public Schools (MPS).

Focus group - Group of parents and students invited to attend a meeting facilitated by staff of CHAW and MCW to answer specific questions related to their oral health knowledge and ability to gain access to dental care.

Dental terms

Comprehensive care - Complete oral health care beginning with prevention, treatment of early and urgent oral health needs, and ongoing care.

Dental caries/decay - destruction of tooth structure caused by bacteria.

Prevention - Oral health procedures, such as oral prophylaxis (dental cleaning), fluoride treatments and sealants that prevent oral health disease.

Restorative care - Surgical treatment of a tooth that removes dental decay and restores the tooth's normal anatomy and physiological function.

Urgent dental treatment - Emergent need for restorative dental care within 24-48 hours of being identified and characterized by pain or infection, swelling, or soft tissue ulceration of more than two weeks duration.

School-based oral health programs - Oral health programs held in schools to provide oral health education and preventive treatment for students on-site. Teams generally consist of a dental hygienist and assistant, and in some cases, a dentist.

Acronyms

CHAW	Children's Health Alliance of Wisconsin
CHW	Children's Hospital of Wisconsin
CSM	Columbia St. Mary's
DHFS	Department of Health and Family Services
EPSDT	Early and Periodic Screening, Diagnostic and Treatment
FQHC	Federally Qualified Health Center
HWPP	Healthier Wisconsin Partnership Program
MATC	Milwaukee Area Technical College
MCW	Medical College of Wisconsin
MPS	Milwaukee Public Schools
MUSoD	Marquette University School of Dentistry
SEALS	Sealant Efficiency Assessment for Locals and States
WHA	Wisconsin Hospital Association

Executive summary

Purpose of the plan

The dental disease burden among children in the City of Milwaukee cannot be ignored. It impacts the overall health of children and their ability to learn. School-based oral health programs, for elementary and middle-school students in the City of Milwaukee, reported untreated decay to be as high as 54 percent during 2005-06. An estimated 68 percent of children under age 18 in the City of Milwaukee were Medicaid eligible, but approximately only 18 percent received a dental exam in 2006.

The purpose of *Healthy Teeth=Healthy Kids*, a plan to improve the oral health of children in Milwaukee, is to serve as a blueprint to address the complex oral health barriers that currently exist. The recommendations are realistic, achievable and measurable, but require diligent efforts by community leaders, providers and policy makers. Significant potential barriers to success can be overcome by focusing efforts on increasing resources, maximizing utilization of the dental workforce and organizing a system of care centered on school-based risk assessments, prevention and referral for treatment.

Mission: Increase the number of children with a permanent dental home, allowing for early prevention, continuity of care and quality treatment.

Overarching goal: Reduce the proportion of children in the City of Milwaukee with active dental decay.

Objectives and key recommendations for action

- 1. Reduce the proportion of children in Milwaukee with urgent oral health needs.**
 - Establish an oral health care referral system linked to comprehensive school-based oral health programs.
 - Develop dental emergency facilities to provide immediate care for urgent oral health needs.
 - Train primary care and community health providers, and school staff to perform annual oral health risk assessments using a standard tool.
- 2. Increase the capacity of clinics and private practices to treat the uninsured and Medicaid populations.**
 - Significantly increase the state of Wisconsin dental Medicaid reimbursement rates and create preferred provider agreements to guarantee access for the Medicaid population.
 - Seek state action to create a single dental benefits administrator to manage oral health care for families covered by Medicaid and other government programs.

Executive summary

- Increase resources to expand existing large clinics and Federally Qualified Health Centers to deliver oral health care.
- Increase the number of dental providers serving the Medicaid and uninsured populations through loan forgiveness programs; amend Wisconsin's exam requirements for state licensure; offer special licensing provisions for foreign-trained dentists; and allow the delegation of duties to auxiliary dental staff.
- Encourage the Milwaukee Area Technical College dental hygiene program to develop broader pediatric and public health dentistry experiences and encourage increased programming.
- Offer dental clinics the resources to utilize services of an oral health consultant to evaluate programs and make recommendations for achieving greater efficiency and quality service.

3. Increase the number of children having access to school-based oral health prevention programs.

- Expand current school-based oral health programs offering comprehensive services.
- Expand early prevention services that target infant and early childhood populations by increasing fluoride varnish applications at pre-school and Head Start centers.
- Increase parental participation in oral health education, prevention and treatment.
- Encourage all schools to support and participate in school-based comprehensive oral health programs and promote annual oral health risk assessments.

4. Increase the role of health care providers in assessing the oral health of Milwaukee children.

- Implement oral health training programs for health care providers working in pediatric and family practice settings, and provide necessary information to refer patients to appropriate oral health care providers.
- Advocate for the Medical College of Wisconsin and the University of Wisconsin Medical School to implement a comprehensive oral health curriculum as part of their formal training of health professionals.

How you can use this plan

The ultimate goal of this plan is to help drive local and state action to improve the oral health care of children in the City of Milwaukee. Key collaborators are identified under each objective in the plan to work on the respective strategies. This plan also will serve as a tool to raise awareness, educate policy makers and legislators, and implement oral health programs.

Cause for concern

Nationwide

Oral health is an integral component of general health and contributes to overall well-being. New research indicates a link between oral and systemic health, such as heart disease, diabetes and low birth weight. Tooth decay (dental caries) is the single most common chronic disease of childhood, occurring five times more frequently than asthma and seven times more often than hay fever.¹ Nationwide 29.5 percent of children have untreated dental decay,² despite it being preventable with the application of early preventive measures, sustainable home care and appropriate periodic professional services.

Statewide

According to the *Make Your Smile Count Survey* conducted by the Wisconsin Department of Health and Family Services (DHFS) in 2001-02, 30.8 percent of the 3,307 third grade children screened were found to have untreated decay in at least one primary or permanent tooth.³ Of these children, 4 percent were determined to have urgent treatment needs.³ Additionally, 44.5 percent of the children from low-income schools, based on a free and reduced lunch rate of greater than 40 percent, had untreated decay compared to only 16.6 percent at high-income schools.³ The need for urgent dental care was 8.4 percent in low-income schools versus 1.5 percent in high-income schools.³ In addition, 36 percent of children in the southeastern region of the state had untreated decay compared to only 19.1 percent in the southern region and 15.2 percent in the western region.³

According to the Wisconsin Hospital Association (WHA) Information Center, Wisconsin hospital emergency departments saw 11,243 Medicaid eligible patients of all ages, for a dental related problem in fiscal year 2004-05. Additionally, 8,463 uninsured patients used the emergency room for a dental related problem. WHA reports that over 95 percent of these visits were due to a preventable problem.

Statewide dental Medicaid data shows that from 2004-06 there was a gradual decrease in both the proportion of Medicaid eligible patients receiving oral health care (-1.49 percent) and the number of Medicaid certified dentists (-112 dentists). In 2006 only 22.6 percent of Medicaid eligible patients received oral health care. In part, this is due to the limited number of Medicaid certified dentists, reported to be 1,220, statewide.⁵ While data from the private sector is not available, utilization is estimated to be 50-70 percent. In the state's fiscal year 2004-05, 40 percent of Medicaid dental providers submitted between 1 and 50 claims, but only 11.8 percent submitted more than 250 claims, which is considered a meaningful volume.⁶

Milwaukee

As we review data on children in the City of Milwaukee, the proportion of children with

¹U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, *Guide to Children's Dental Care in Medicaid*, October 2004.

²Centers for Disease Control and Prevention (CDC), *National Oral Health Surveillance System*, 2007.

³Wisconsin Department of Health and Family Services, *Make your Smile Count Survey*, 2002.

Cause for concern

untreated decay is disproportionately higher than the rest of the state. Statistics from two local school-based oral health programs show the rate of untreated decay in program participants to be 54 percent, of which, 14.8 percent was considered urgent.⁴ These programs target low-income schools based on high free and reduced lunch rates, typically exceeding 60 percent. This untreated decay rate far exceeds not only the state averages, but also those for low-income schools in Wisconsin.³ According to 2005 census data, there are 162,156 children under age 18 in the City of Milwaukee with approximately 111,000 of those being Medicaid eligible. Only 18 percent of these children received a dental exam in 2006.^{5,6}

Statistics represented in Figures I and II below show the astounding need for increased access to comprehensive oral health care for children in the City of Milwaukee. Every child should be able to learn in school, live free of mouth pain and avoid other health issues related to poor oral health.

Figure I: decay and urgency rates^{2,3,4}

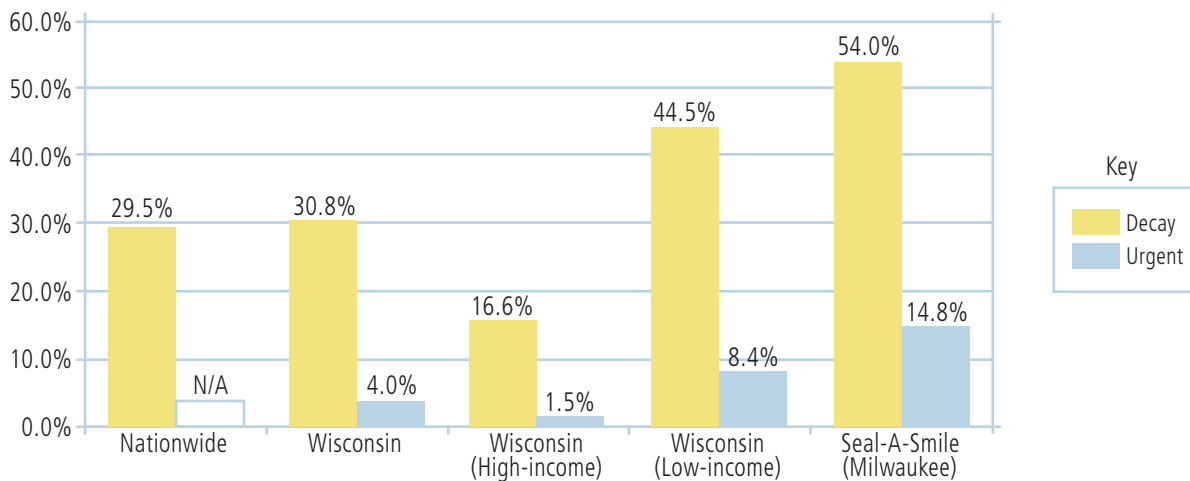
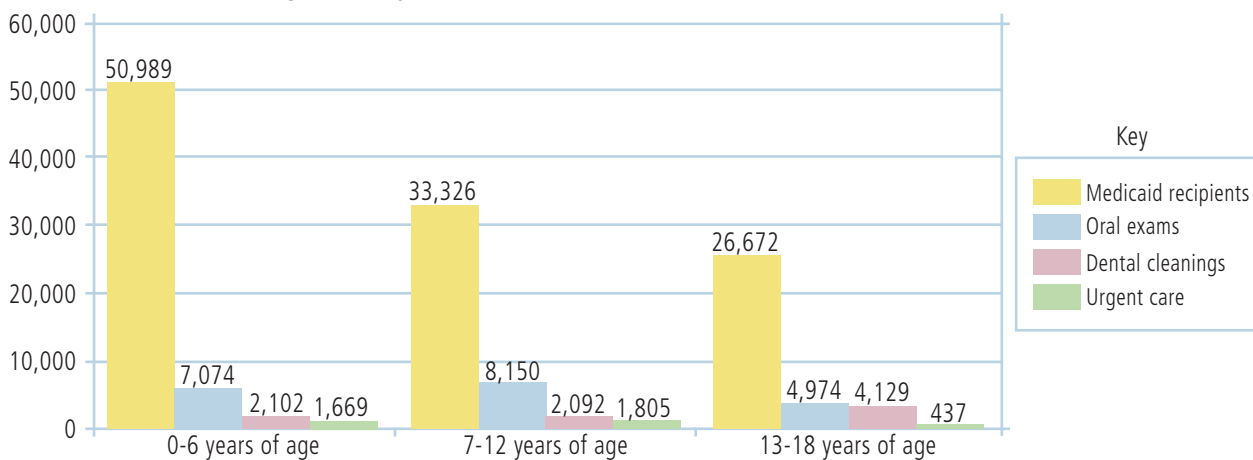


Figure II: City of Milwaukee Medicaid utilization⁵



⁴Children's Health Alliance of Wisconsin, *Sealant Efficiency Assessment for Locals and States (SEALS)*, 2005-06.

⁵Wisconsin Department of Health and Family Services, Medicaid Division, 2007.

⁶City of Milwaukee census data, 2005.

Process for development

Many in the Milwaukee community understand the need and importance of good oral health care for children. However, in order to effectively ensure access to oral health care for children in the underserved areas of Milwaukee, proactive planning and action is essential. Input for improving oral health care was gathered from key partners, community stakeholders and focus groups with the intent to create this plan.

Key partners

The key partners who led this planning effort and continue to be an integral part of the process are Children's Health Alliance of Wisconsin (CHAW), Children's Hospital of Wisconsin (CHW) Dental Center, Marquette University School of Dentistry (MUSoD), Medical College of Wisconsin (MCW) and Milwaukee Public Schools (MPS).

The spirit and intent of the key partners was to bring people together to collect ideas, develop solutions and reach unanimous consent on a plan of action for improving oral health care for children. The key partners met over the course of a year to gather information and guide the process for developing a feasible action plan.

Community stakeholders

Key partners identified community stakeholders in the City of Milwaukee who touch the lives of children who need oral health care. These community stakeholders included private dental and medical providers, dental and medical clinics, Federally Qualified Health Centers (FQHC), school personnel, state public health officials, community organizations and others. CHAW staff met with community stakeholders individually to gather detailed information and ideas. Information was gathered through key informant interviews rather than in a group setting to ensure each stakeholder's voice was heard. The information provided was candid and detailed, serving as an invaluable guide to preparing this plan.

Focus groups

CHAW and MCW staff conducted three focus groups. Thirteen parents of Head Start and school-age children participated in focus groups at Bruce Guadalupe school and the Next Door Foundation. Eight students, 12-15 years of age, participated in the third focus group at Westside Academy II. The purpose was to obtain information related to their knowledge of oral health, and experience in accessing and receiving care. A detailed summary of the focus group results can be found in Appendix A, however, the following themes emerged from the focus group discussions:

- The student focus group had a better understanding than the parent focus group on the importance of good oral health care.
- Transportation to a dental office was not a barrier for these parents, however, finding a dentist willing to accept Medicaid was a significant barrier.
- Parents preferred their children receive oral health care in a dental office rather than an alternative location, such as a mobile unit, neighborhood center or school.

Process for development

- Parents that have a school-based oral health program are comfortable with their children receiving prevention and screenings at school.
- Students preferred receiving treatment in a dental office, however, were open to receiving prevention and screenings at school or other community settings.

Facilitator note: Background information was not given to students or parents on the operation or structure of a mobile clinic or portable school-based unit. This enabled the facilitators to obtain a baseline for the level of knowledge participants had and their initial reaction to alternative practice settings.

Additional research

Earlier reports on access to dental care were reviewed in the development of this plan. Below is a summary of recommendations contained in the reports:

1. MUSoD report *Access to Dental Care and Promoting Oral Health in the City of Milwaukee: A planning project.*

- Develop a surveillance program to evaluate the progress in resolving the problem with access to dental care and progress in oral health outcomes of underserved residents in the City of Milwaukee. The surveillance program will include a formal and ongoing analysis of the Medicaid data, collection of data from recipients of dental care from FQHC dental clinics and private dentists serving low-income patients; and periodically survey residents in low-income areas of the city.
- Develop a new model for provision of dental care that encourages private dentists to partner with FQHCs to obtain funding through cost-based reimbursement.
- Develop a pilot triage model that includes all the relevant stakeholders. This opportunity will allow for the evaluation of the model's effectiveness, efficiency and sustainability in addressing access to oral health care. This model will allow for ongoing data interpretation useful for policy development.

2. Governor's Task Force to Improve Dental Access to Oral Health.

- Increase workforce recruitment, training and loan assistance.
- Increase MUSoD enrollment of Wisconsin residents.
- Increase funding for community water fluoridation.
- Expand settings where dental hygienists can practice independently of a dentist.
- Increase state Medicaid budget by \$20 million.
- Accept all four regional dental licensure exams and create a pathway for foreign-trained dentists to receive licensure in Wisconsin.
- Increase oral health safety net program funding.
- Increase awareness that children with severe oral health disease qualify for targeted case management under the Children with Special Health Care Needs program.
- Increase funding for state Regional Oral Health Consultants.

Process for development

- Increase lobbying efforts to secure federal funding for oral health education, treatment and integration in all health care fields.
- Detailed task force recommendations can be found by visiting the following Web site, http://dhfs.wisconsin.gov/health/Oral_Health/taskforce/index.htm.

The following information was gathered and reviewed prior to the development of the plan:

1. Site visit by CHAW staff to a dental mobile unit serving students in Madison area schools and rural communities in Southwestern Wisconsin. This visit provided information on the operation and funding of a mobile unit, helping to determine the feasibility of such a model working in the City of Milwaukee.
2. Inventory of current oral health services available for underserved populations in the City of Milwaukee. This information identifies the capacity of oral health programs currently operating in Milwaukee and can be found in Appendix E.
3. Medicaid data from DHFS that illustrates utilization of dental services of children in the City of Milwaukee can be found in Appendix F.

Recommendations

Mission: Increase the number of children with a permanent dental home, allowing for early prevention, continuity of care and quality treatment.

Overarching goal: Reduce the proportion of children in the City of Milwaukee with active dental decay.

Baseline: A convenience sampling from two local school-based oral health programs in 2005-06 show the rate of untreated decay in program participants to be 54 percent.

Target: Reduce untreated decay rates below the state average for low-income schools (44.5 percent) after one year of implementation and reduce to, at or below, the state average for all schools (30.8 percent) after three years as reported in the *Make Your Smile Count Survey*.

Data sources: Milwaukee SEALS data, 2005-06; Wisconsin DHFS *Make Your Smile Count Survey*, 2001-02.

Outcome measure method: Continue to collect data on untreated dental decay from school-based programs and compare to baseline data.

Key collaborators: Community stakeholders, key partners and members of the community.

Recommendations

Objective 1 - Reduce the proportion of children in Milwaukee with urgent oral health needs.

Baseline: Urgent needs were found to be 8.6 percent in the Southeastern region (Jefferson, Kenosha, Milwaukee, Ozaukee, Racine, Walworth, Washington, and Waukesha Counties) and 14.8 percent in Milwaukee schools.

Target: Reduce urgent oral health needs to below the state average (4 percent) as reported in the *Make Your Smile Count Survey*.

Data sources: Milwaukee SEALS Data, 2005-06; Wisconsin DHFS *Make Your Smile Count Survey*, 2001-02.

Outcome measure method: Continue to collect data on urgent oral health needs from school-based oral health programs and compare to baseline data.

Key collaborators: Children's Health Alliance of Wisconsin, community organizations, local community leaders and advocates, school-based oral health programs.

Note: The percentage of children with urgent treatment needs in the Southeastern region is two times the statewide level. Children in the City of Milwaukee had urgent treatment needs three and half times the statewide level. This illustrates a disparity within Wisconsin's largest urban area.

Strategies:

1. **Establish an oral health care referral system to assist parents and families in the process of obtaining oral health care for their Medicaid insured or uninsured child. The referral system would connect families with oral health care providers willing to provide services at Medicaid rates or no cost to the uninsured on a limited basis.**

Rationale: This would ensure the utilization of services currently available and potentially increase the provider's willingness to accept new or additional Medicaid clients because of coordinated communication between the dental office and family.

Action steps:

- a. Identify funding to sustain an oral health care referral system.
- b. Hire a full-time oral health care coordinator(s) as part of the school-based programs to facilitate the placement of children with urgent and early dental needs into a dental home.

Recommendations

- c. Identify providers willing to treat oral health needs, facilitated by the oral health care coordinator(s).
- d. Utilize an electronic scheduling program, such as Global Health Direct.

2. Develop dental emergency facilities for patients with urgent oral health needs.

Rationale: An organized system of urgent care services would allow for greater efficiency in connecting children who have urgent needs.

Action steps:

- a. Identify private dental offices and clinics willing to provide urgent care and link this information to the oral health care coordinator(s).
- b. Based on future dental caries risk, refer patients receiving urgent care to a dental home for follow-up and non-urgent ongoing care.
- c. Create a dental clinic(s) to provide urgent and primary oral health care to children in community-based organizations.
 - Conduct a feasibility study and develop a business plan.
 - Identify an administrator.
 - Identify a funding source(s).

3. Increase the proportion of children who receive annual risk assessments.

Rationale: Risk assessments are an evidence-based tool that identifies early problems and urgent needs that may otherwise go unaddressed. The earlier oral health care can be received, the better.

Action steps:

- a. Identify a standard oral health risk assessment tool for use among all providers and programs screening children.
- b. Include the risk assessment as part of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) visit and require completion for EPSDT reimbursement.
- c. Triage children based on the risk assessment so those at higher risk are seen more frequently.
- d. Train all pediatric and family medicine providers, school and community health workers to assess a child's oral health status and provide workers with resources to refer appropriately.

4. Increase local community's role in connecting families with oral health care services.

Rationale: When residents in the community become involved in the solution and have ownership of programs, there is greater support and participation.

Recommendations

Action steps:

- a. Identify community advocates and leaders to be liaisons between families and the oral health care coordinator(s).
- b. Encourage community advocates to stress the importance of finding a dental home.
- c. Implement programs, such as ClearPath, which educates families on their responsibilities as well as those of the dental office. Programs like ClearPath guarantee shorter appointment wait times, helping to reduce a common frustration between families and providers.

Objective 2 - Increase the capacity of clinics and private practices to treat the uninsured and Medicaid population.

Baseline: In 2006, 18 percent of Medicaid eligible children in the City of Milwaukee received an oral exam.

Target: Increase the percentage of children receiving an oral exam to 50-70 percent within three years, based on the estimated anecdotal data of private sector utilization.

Data sources: Wisconsin Medicaid, Delta Dental of Wisconsin claim information.

Outcome measure method: Review aggregate claim data from Medicaid and Delta Dental of Wisconsin for 3-5 years.

Key collaborators: Children's Health Alliance of Wisconsin, Department of Health and Family Services, Doral Dental USA, Milwaukee Health Services Inc., Southeast Dental Associates, Sixteenth Street Community Health Center, Westside Health Care Association.

Strategies:

1. Significantly increase the state of Wisconsin dental Medicaid reimbursement rates.

Rationale: Current dental Medicaid rates in Wisconsin fall between the 1st and 20th percentiles in our region for reimbursement. Other states have experienced significant increases in provider participation, claim submission and overall utilization after a significant rate increase. Focus group findings show that patients who have Medicaid coverage want to be seen in a regular dental office similar to the privately insured. This calls for more private dentists to become Medicaid providers. Currently less than 1 percent of the Medicaid state budget is devoted to oral health. An increase to 2 percent, or \$20-30 million per year, would allow rates to potentially be raised as high as the 75th percentile. A listing of current Medicaid and private practice fee schedules can be found in Appendix G.

Recommendations

Action steps:

- a. Increase Medicaid reimbursement by increasing the current Medicaid budget.
- b. Build in a gradual increase over 3-5 years in order to monitor provider participation and increase access for Medicaid patients.
- c. Create *preferred provider* agreements between the state of Wisconsin and dental clinics willing to guarantee access and service to Medicaid eligible children.

2. Seek state action to create a single dental benefits administrator for the purpose of managing oral health care for families covered by Medicaid and other government programs.

Rationale: This option would remove dental claim processing and customer service from the state HMO and fee-for-service systems, and allow for a greater provider network.

Action steps:

- a. Provide the state with a proposed model for a dental benefits administrator that includes management of access and services.
- b. Obtain data supporting increased dentist participation in a Medicaid program administered through a third party.
- c. Outline a model showing the cost and access benefits of creating a single administrator.

3. Increase resources to expand existing large clinics (three or more full-time dentists) and capacity of FQHCs to deliver oral health care.

Rationale: Current providers have experience in working with families and the infrastructure for billing government programs.

Action steps:

- a. Provide collective support and assistance to Columbia St. Mary's (CSM) Madre Angela Dental Clinic, CHW Dental Center, Westside Health Center, and Milwaukee Health Services Inc., to expand or create satellite clinics by seeking public and philanthropic funding.
- b. Encourage private dentists to partner with FQHCs to obtain cost-based reimbursement.

4. Increase the number of dental providers serving the Medicaid and uninsured populations.

Rationale: Increasing the number of dental providers serving government funded programs and the uninsured would create greater access for patients seeking care. A current listing of Milwaukee pediatric Medicaid providers who are accepting new patients can be found in Appendix D.

Recommendations

Action steps:

- a. Increase funding for the state's health care provider loan forgiveness program and extend the dentist loan forgiveness program to practitioners working in any federally designated health professional shortage area.
 - b. Amend current Wisconsin law to accept the ADEX exam or any one of the four regional clinical dental exams to apply for licensure.
 - c. Allow foreign-trained dentists to apply for Wisconsin licensure after successful completion of the national written dental exam, and either the ADEX exam or one of the four regional clinical dental exams.
 - d. Introduce legislation that would change current regulation and licensure rules that prohibit the delegation of duties to auxiliary dental staff.
 - e. Encourage the Milwaukee Area Technical College (MATC) dental hygiene program to develop broader pediatric and dental public health experiences within the current curriculum. Encourage increased programming between MATC dental hygiene school, CHW Dental Center, Madre Angela Dental Clinic, Milwaukee area FQHCs and Head Start centers.
- 5. Offer dental clinics the services of an oral health consultant to evaluate their programs and provide recommendations for achieving greater efficiency and quality service.**

Rationale: Office protocols and utilization of staff can often impact the efficiency and delivery of services. In order to maximize available resources and reach as many children as possible, a review of operations would be helpful.

Action steps:

- a. Identify potential consultants in the field or create volunteer teams willing to evaluate clinic operations, and offer recommendations in the spirit of improving access and efficiency.

Objective 3 - Increase the number of children having access to school-based oral health prevention programs.

Baseline: School-based oral health programs are available to approximately 2.5 percent of students in Milwaukee schools according to 2005-06 Seal-A-Smile data.

Target: Within three years 40 percent of children will have access to a school-based oral health prevention program. Each subsequent year will increase participation by 5-10 percent until all children have access to a program.

Data sources: Milwaukee SEALS data, 2005-06; City of Milwaukee census data, 2005. Reliable

Recommendations

and valid measures of oral health outcomes do not exist and need to be developed, validated and incorporated into practice.

Outcome measure method: Compile data from annual oral health risk assessments.

Key collaborators: Children's Health Alliance of Wisconsin, Columbia St. Mary's Madre Angela Dental Clinic, Dental Hygiene Association of Wisconsin, Milwaukee Public Schools, Wisconsin Dental Hygiene Association.

Note: The school-based programs will serve as the key focal point for oral health risk assessment, determining individual needs, oral health education and the provision of prevention services, such as cleanings, sealants and/or fluoride applications. Schools are targeted using free and reduced lunch rates. A listing of Milwaukee Public Schools can be found in Appendix C.

Strategies:

1. Expand current school-based oral health programs modeled after the CSM School-based Oral Health Program.

Rationale: As confirmed in focus groups, school-based programs are successful in raising awareness, educating children and families on proper oral health and nutrition, and linking to treatment. By reinforcing prevention in schools, the amount of new untreated decay can be reduced.

Action steps:

- a. Identify funding sources beyond Medicaid reimbursement to sufficiently fund school-based oral health teams. It is estimated that 14 teams are needed to provide service to all Milwaukee schools. See Appendix B for more information.
- b. Work with MPS and other area schools to coordinate and schedule site locations and children to be served.
- c. Contract for services through FQHCs to allow for cost-based reimbursement.

2. Expand early prevention services that target infant and early childhood populations.

Rationale: Early prevention reduces the risk of future oral health disease.

Action steps:

- a. Increase pre-school and Head Start fluoride varnish applications.
- b. Promote prevention programs with Head Start and early childhood leaders.

Recommendations

3. Increase parental participation in education, prevention and treatment.

Rationale: Parents are responsible for the overall health of their children and can directly impact positive oral health behavior.

Action steps:

- a. Invite parents to be part of their child's oral health treatment at school and in private practice.
- b. Educate parents on the importance of good oral health care and its impact on overall health.
- c. Educate parents on nutrition that decreases risk factors associated with poor oral health and encourage healthy food choices.
- d. Utilize multiple venues for education including one-on-one counseling, group meetings, brochures and media.

4. Encourage all schools to support and participate in school-based comprehensive oral health programs each year.

Rationale: Providing care in child care settings and schools reduces lost classroom time for students and provides easy access to children who otherwise would not see a dentist. Providing direct care in the schools is an excellent opportunity to raise awareness of good oral health care among children, parents and school faculty.

Action steps:

- a. Encourage child care settings and schools to offer school-based oral health programs.
- b. Integrate oral health programming into state and local educational learning targets.

Objective 4 - Increase the role of health care providers in assessing the oral health of Milwaukee children.

Baseline: Currently, only Head Start programs require an annual exam for students due to a federal mandate. In addition, children served by the CSM and MUSoD school-based programs also receive annual assessments.

Target: Increase the number of children receiving oral health risk assessments to at least 80 percent after five years.

Data sources: Medicaid utilization data, Milwaukee area Head Start programs and child care centers.

Recommendations

Outcome measure method: Measure the increase in programs providing oral health risk assessments.

Key collaborators: CHW Dental Center, Medical College of Wisconsin (Department of Pediatrics), health professional training institutions.

Note: By assessing the mouth of a child, a clinician can identify a potentially life threatening problem. Clinicians are a credible voice able to provide direction to parents and caregivers. Increased awareness in the health care community will help emphasize the importance of regular oral health care. Educating parents at visits is critical. The focus groups found, in general, parents had less education on healthy nutrition, oral health instruction, and good oral health care than the participants in the student focus group.

Strategies:

1. Implement an oral health training program for health care providers who work in pediatric and family practice settings.

Rationale: By identifying oral disease in a child at an earlier age, the severity of the disease can be greatly reduced.

Action steps:

- a. Use the Wisconsin Regional Oral Health Consultant curriculum developed by the DHFS Oral Health Program. Visit http://dhfs.wisconsin.gov/health/Oral_Health for more information.
- b. Provide annual citywide training for health care professionals, demonstrating what to look for at well-baby and child checks.

2. Give health care professionals the necessary information to refer patients to an appropriate oral health care provider.

Rationale: Many health care providers are frustrated with the lack of referral sources for patients with severe dental decay. This resource will allow for appropriate and timely referrals.

Action steps:

- a. Provide a detailed listing of oral health care providers and connect patients with the oral health care coordinator(s).
- b. Research programs, such as Global Health Direct for online appointment scheduling.

3. Advocate for Medical College of Wisconsin, the University of Wisconsin Medical School and other health professional training institutions to implement a comprehensive oral health curriculum as part of their formal training.

Recommendations

Rationale: Comprehensive oral health history and assessment should become embedded as part of the standard health exam.

Action steps:

- a. Train future health care professionals to integrate an oral health assessment into annual patient exams.
- b. Encourage and train pediatricians to apply fluoride varnish to children ages 0-12 with high carries risk and no dental home.

4. Recommend that local school districts promote annual oral health risk assessments prior to enrollment.

Rationale: School districts that have implemented similar programs have seen positive results. Problems identified at an early stage can be treated before they impede learning.

Action steps:

- a. Consult with school districts on the importance of annual oral health risk assessments.
- b. Offer on-site assessments at registration.
- c. Encourage all child care settings and schools to support and participate in annual school-based comprehensive oral health programs.

Role of community

Every person and community institution with an interest in healthy successful children plays a role in ensuring access to oral health care. In order for oral health access to improve, a network of community leaders must collectively step forward. Large or small, everyone can contribute.

Key steps every individual and organization can continue working toward:

- **Increasing personal knowledge on the importance of good oral health care and the link to other serious health issues.**
- **Becoming aware of who provides oral health care to children in the community.**
- **Advocating for children's oral health services in the community.**
- **Becoming a community spokesperson for educating others on the relationship between oral health and physical health.**

In addition, there are specific roles individuals and organizations can continue to emphasize as we work toward improving the oral health of children:

Business leaders:

- Provide quality dental plans to employees and promote the value of good oral health and its link to overall health.

Celebrities:

- Use the visibility and popularity of state, local and national celebrities to deliver positive messages and advocate for quality services for children.

Clinicians:

- Assess the mouths of patients and advocate for early dental visits.
- Provide fluoride varnish when appropriate and/or delegate to others.
- Require additional oral health care when treating pregnant women or other patients with health conditions positively impacted by frequent dental care.
- Seek additional training or information on dental caries and its relationship to overall health.
- Perform annual oral health risk assessments.

Community organizations:

- Share stories about children and families in need of oral health services to demonstrate the problem.
- Share success stories of children receiving oral health care.
- Educate families on the importance of practicing and obtaining good oral health care.
- Develop and implement initiatives that build partnerships between Medicaid insured families and dental providers.

Day care providers:

- Seek community oral health prevention programs serving children.

Role of community

- Become knowledgeable on the impact oral disease can have on young children.
- Provide information to parents on how to locate a dental home.
- Educate families on the importance of practicing and obtaining good oral health care.
- Perform annual oral health risk assessments.

Dental hygienists:

- Increase involvement in school-based prevention programs.
- Provide maximum chair side education as the voice of knowledge and credibility.
- Perform annual oral health risk assessments.
- Become members of the state dental hygiene associations.
- Become a certified Medicaid provider and explore alternative work settings such as school-based oral health programs, local public health departments and FQHCs.

Dental students/Dental hygiene students:

- Embrace the mission of serving disadvantaged populations.
- Seek community experiences in serving underserved populations and consider practicing public health dentistry upon graduation.
- Seek additional training, during and after, formal education to gain experience in treating children.

Dentists:

- Treat a greater number of families covered by Medicaid or other government programs.
- Offer non-traditional office hours to accommodate working families.
- Increase utilization of dental hygienists and assistants to maximize treatment procedures.
- Provide maximum chair side education as the voice of knowledge and credibility.

Government leaders:

- Remove administrative barriers for health care providers willing to provide care to the underserved.
- Work with legislative representatives to identify reasonable funding sources.
- Work with local communities to tailor creative oral health programs to reach the underserved.

Health professional students:

- Incorporate oral health screenings into patient visits.
- Research the relationship between oral health and physical health.
- Lead the charge to overcome decades of separation between the body and mouth.
- Become involved in oral health community projects.
- Perform annual oral health risk assessments.

Hospitals:

- Advocate for an increase in oral health access to reduce the number of expensive preventable

Role of community

emergency room visits absorbed by hospitals each year.

- Collect data on costs and utilization related to emergency dental needs that would have been avoided if early intervention had occurred.

Local elected officials:

- Support local initiatives in the community devoted to treating the underserved.

Local Public Health Departments:

- Create or expand a school-based oral health program to compliment the current health services offered through the department.
- Employ or contract with oral health professionals to provide education and assist with treatment services.
- Perform annual oral health risk assessments.

Marquette University School of Dentistry:

- Increase opportunities for students to participate in community oral health programs and treat underserved children.
- Increase the emphasis on evidence-based dental care and how it impacts overall health.

Media venues, print/electronic:

- Provide the public with information on the importance of oral health care and the impact on overall health.
- Provide editorials on the need for dental services and its positive impact on children.
- Educate the public on the resources Wisconsin and other states commit to oral health care when compared to general health care.
- Share stories with the public on how children and families are impacted positively by oral health services or negatively by the lack of services.

Medical College of Wisconsin and University of Wisconsin Medical Schools:

- Increase the oral health education component within the medical school curriculum.
- Provide additional training on the correlation between oral and systemic disease.
- Provide greater opportunity for medical students, residents and fellows to observe and participate in oral health programs and the delivery of services.

Milwaukee Area Technical College Dental Hygiene Program:

- Increase opportunities for students to experience community oral health programs and treat underserved children.
- Increase the emphasis on evidence-based dental care and how it impacts overall health.

Nurses:

- Communicate good oral health practices to patients.

Role of community

- Provide fluoride varnish applications when appropriate.
- Perform annual oral health risk assessments.

Parents:

- Practice good oral hygiene with your child.
- Begin brushing your child's teeth at infancy.
- Provide only healthy, nutritious snacks for your child.
- Encourage daycare centers to brush your child's teeth after meals.
- Advocate for school-based oral health programs at your child's school.
- Inform your legislators if you have problems accessing oral health care for you or your child.

Philanthropic community:

- Support efficient programs with measurable outcomes that improve the oral health of children and their ability to successfully learn in school.

School nurses/social workers:

- Perform annual oral health risk assessments.
- Collect data on needs of students.
- Monitor health conditions impacted by dental disease, such as diabetes.
- Serve as a liaison to the family in communicating dental needs.
- Be a resource for helping families find dental homes or treatment services.

State lawmakers:

- Support legislative initiatives that remove barriers and increase access to quality oral health care.

Teachers/principals:

- Embrace school-based oral health programs.
- Advocate for resources and policy from the school board.
- Educate parent-teacher organizations to garner support for increased oral health services.
- Identify and document stories of how student learning is impacted positively by dental services or negatively by the lack of services.

Wisconsin Dental Association:

- Encourage its membership to increase dental care to the underserved Medicaid community.
- Advocate for innovative solutions to the access crisis.

Wisconsin Dental Hygiene Association/Dental Hygiene Association of Wisconsin

- Encourage a greater number of dental hygienists to become members of one or both of the state dental hygiene organizations to help foster ideas from each organization.
- Encourage and educate members on becoming certified Medicaid providers and working in settings that serve the Medicaid and uninsured communities.

Conclusion

After examining the oral health needs of children in the City of Milwaukee, serious action must be taken to improve their oral health. While this plan calls for significant new resources and changes in service delivery, implementation will be achieved by following each objective. This plan is meant to serve as a blueprint to address complex oral health barriers faced by families in the City of Milwaukee. The recommendations are realistic, achievable and measurable, but will require diligent and ongoing collaboration. Most importantly, the oral health needs of children will only be served if there is strong commitment among parents, community leaders, providers and policy makers.

Appendix A

Summary of focus group results

Transcription prepared by Becky Martin; analysis compiled by Tiffany Frazer, Drs. Sima Patel and Alexandria Saulsberry; Advisor: Earnestine Willis, MD, MPH, March 2007.

Each of the three focus groups met approximately 45 minutes. Facilitators were Tiffany Frazer, Drs. Sima Patel and Alexandria Saulsberry from MCW. Participant questions were answered after each session by Matt Crespin from CHAW. Sessions were audio taped and transcribed. Transcripts from each session were reviewed and general themes were identified.

Recruitment methods

Parents: (dates: 2-8-07, 5-21-07 - participants: 13)

- Had children enrolled at Next Door Foundation's Head Start and Bruce Guadalupe Elementary School.
- Received flyers sent home with children and posted throughout the building.
- Were recruited by teachers and nurses.
- Signed consents before focus group began.
- Received children's books, toothbrushes, paste and basic oral hygiene instructional handouts following the session.

Youth: (date: 2-22-07 - participants: 8)

- Were enrolled at Westside Academy II, a Milwaukee charter school.
- Forms were filled out by their caretakers and returned to school.
- Received toothbrush, paste, cookies and basic oral hygiene instructional handouts following the session.
- Ranged from ages 12 to 14.

Three themes identified

1. There are gaps in knowledge about basic oral health care.

When questioned about basic knowledge of oral health, parents only stated the need for six-month visits, but no other correlation was acknowledged. Parents did not comment on the relationship between good oral health care and overall health. Parents of children with school-based oral health programming at Bruce Guadalupe School were well versed in appropriate timeframes for dental visits, the need to brush daily after each meal and providing snacks appropriate for their child's teeth. These parents were aware of the relationship between good oral health care and overall health. Youth also were aware of the need to brush three times a day. They acknowledged the preventive role of brushing teeth in avoiding cavities and the need for mouthwash. They seemed to acknowledge a general relationship between good oral health care and overall health. For example, it was stated that *infections originating in the mouth could*

Appendix A cont.

spread to the body. They also stated *the development of cancer in the mouth could affect the body.* Neither group was clear about the differing roles of the dentist, dental hygienist and dental assistant.

Few parents knew about sealants, nor commented on why sealants were important, though they acknowledged that fluoride treatments had a preventive role in oral health care and strengthening teeth. Youth seemed aware of the purpose and application process of sealants.

Parents had questions regarding acute issues or personal problems regarding their teeth (e.g., management of cavities and chipped teeth, and the need for filing teeth). Youth had questions regarding a variety of dental topics, including the reasons behind certain procedures, oral pathology and tooth development/eruption.

Those with a *dental home*, were comfortable discussing oral health with their dentist.

2. Accessing oral health care can be frustrating.

Parents and youth stated they have trouble making appointments for both routine and urgent care.

a. The process of getting an appointment is lengthy and complex.

- Parents voiced frustration about the process that included calling a hotline to obtain a list of providers. After contacting providers, parents reported having to wait 3-4 months, on average, for an appointment.
- Youth voiced frustration about waiting room times being too long. They also reported the rooms were too small and crowded.

b. All agreed getting an appointment was difficult.

- Availability of appointments does not match parents' work schedules. They acknowledged appointments were easy to forget, given they are scheduled so far in advance.
- Youth mentioned the appointments were inconvenient, requiring them to miss school.
- All participants denied transportation to appointments was a problem, however, finding a dentist willing to accept Medicaid was a significant barrier.
- Most parents have been forced to see a dentist outside the City of Milwaukee that accepts Medicaid.

3. Concerns about quality of care and safety exist, especially with regard to alternative dental care services.

Both parents and youth felt office-based dental practices would provide the best care. Initially, both questioned school-based dental care and highly questioned mobile van-based dental care facilities. They later expressed willingness to try these services if providers were professional, displayed a diploma or came highly recommended.

Appendix A cont.

- Parents stated they are willing to use a mobile van for dental hygiene and other basic oral health care. They stated a desire to be present at their child's first dental visit in an alternative setting.
- Parents with a school-based oral health program in their child's school are comfortable with their children receiving oral health prevention and screenings at school.
- Youth also questioned school-based dental care. Those who received oral health services at school acknowledged getting care without problems. Youth with prior knowledge of alternative dental care facilities were more comfortable with this type of delivery.

Suggestions/observations:

1. Evidence suggests youth have better exposure to oral health education than parents.

- There is benefit in continuing and expanding dental education for school-age children.
- Parents of children in school-based oral health programs have a greater knowledge of oral health care needs than those without.

2. While actual dental visits are satisfactory, waiting room experience and appointment wait times are frustrating.

- Frustration could be alleviated through more convenient hours and child friendly waiting rooms.

3. Proceed cautiously when considering alternative models (mobile units, school-based, community based organizations) to increase access to oral health care.

- There needs to be increased public education regarding the alternative models' scope-of-services.

Appendix B

Model and budget for school-based oral health teams

Each school-based oral health team consists of a registered dental hygienist and dental assistant. The team uses portable equipment transported to and from schools. School staff is briefed on the services that will be provided and will distribute consent forms to students before the team arrives at the school. The school coordinator of the project will work with parents to ensure consent forms are returned on time so the team can see as many students as possible.

Upon arriving at the school, the team will set up the equipment in a designated space. Depending on the space availability, more than one team may be at a site. Each team has two dental chairs and appropriate equipment (i.e. compressor, stools, lights, instruments, etc.) to provide preventive oral care. The dental assistant will provide students with oral hygiene instructions, an explanation of services and answer any questions. Then, the dental hygienist will provide the necessary preventive care. This process is repeated for the next student so each team is working with two students during each time frame for the remainder of the day.

Upon completion of a dental cleaning, application of fluoride varnish and placement of any sealants, students are evaluated for other oral health problems. If necessary, students are referred to a dental clinic, FQHC or private office for restorative work. Students with urgent oral health needs are triaged and linked with a case manager to ensure prompt care. These students are seen again the following year through the school-based program or become patients at a private office. Whether students are seen in the school-based program each year or have a dental home, the goal is for all students to receive ongoing quality care.

Expenses: (one team can treat approximately 1,000 students per school year)

One-time expense:

- Equipment: (2 patient chairs, 2 operator stools, 1 compressor, 2 overhead lights, 1 curing light, 10 instrument set-ups and laptop) = \$15,000.00

Annual expenses:

- **Consumable goods:** (gloves, masks, disposables, fluoride varnish, sealant material and oral hygiene aids) = \$7,600.00
- **Salaries/benefits:** (fringe benefit rate = 32%)
 - Dental hygienist = \$53,000
 - Dental assistant = \$28,100
 - Data/insurance specialist = \$5,200
 - Program coordinator = \$10,400(Total salaries = \$96,700)
- **Travel and transport** = \$3,000

Total annual expenses: \$107,300

Appendix C

Milwaukee Public Schools free and reduced lunch rates - April 2007

School	% on FRL
Lee School	97
Douglass School	94
Holmes School	94
La Follette School	94
Grand Avenue School	94
Allen-Field School	93
Forest Home Avenue School	93
Lincoln Avenue School	93
Twenty-First Street School	93
Keefe Avenue School	93
Story School	93
Hayes Bilingual School	92
Pierce School	92
Carver Academy	92
Longfellow School	92
Mitchell School	92
Townsend School	92
Maple Tree School	91
Wisconsin Avenue School	91
Auer Avenue School	91
Kosciuszko Middle School	91
Hampton School	90
Bethune Academy	90
Clarke Street School	90
King Elementary School	90
Mc Nair Academy	90
Metcalfe School	90
Vieau School	90
Scott Middle School	90
Browning School	89
Hi-Mount School	89
Clemens School	88
Garden Homes School	88
Thirty-Eighth Street School	88
Franklin School	88
Greenfield School	88

School	% on FRL
Hopkins Street School	88
Burroughs Middle School	88
Muir Middle School	88
Webster Middle School	88
Edison School	88
Brown Street Academy	87
Granville School	87
Green Bay Avenue School	87
Kluge School	87
Lloyd Street School	87
Riley School	87
Bruce School	86
Bryant School	86
Carleton School	86
Cass Street School	86
Thirty-Fifth Street School	86
Dover Street School	85
Silver Spring School	85
Doerfler School	85
Emerson School	84
Happy Hill School	84
Carson Academy of Science	84
Seher School	83
Wheatley School	83
Gaenslen School	83
Kagel School	82
Kilbourn School	82
Philipp School	82
Sherman School	82
Urban Waldorf School	82
Wisconsin Conservatory of Lifelong Learning	82
Milwaukee Education Center	82
Barton School	81
Lancaster School	81
Milwaukee Sign Language School	81
Starms Discovery School	81

Appendix C cont.

Milwaukee Public Schools free and reduced lunch rates - April 2007

School	% on FRL
South Division High School	81
Hawthorne School	80
Sixty-Fifth Street School	80
Thurston Woods	80
Lincoln Center of The Arts	80
Grant School	79
Grantosa Drive School	79
Bell Middle School	79
Foster and Williams Visual Communication	79
Engleburg School	78
Fratney Street School	78
Neeskara School	78
Parkview School	78
Custer High School	78
Fifty-Third Street School	76
Thoreau School	76
Bay View High School	76
Marshall High School	76
WHS of Expeditionary Learning	76
WHS of Law Education and Public Service	76
Burbank School	75
Metropolitan High School	75
Pulaski High School	75
Vincent High School	75
River Trail School	74
WHS of Information Technology	74
Stuart School	73
Zablocki School	73
Madison University High School	73
Eighty-First Street School	72
North Division High School	72
Congress School	70
Goodrich School	69
Morgandale School	69
Morse Middle School	69
Curtin School	68

School	% on FRL
Lowell School	68
Victory School	67
Hawley School	66
Hartford University School	66
Manitoba School	65
Trowbridge School	65
Bradley Technology and Trade School	65
Riverside University High School	65
Roosevelt Middle School	64
Garland School	63
Hamilton High School	63
Academy of Accelerated Learning	62
Macdowell Montessori School	62
Reagan High School	62
Clement Avenue School	61
Whitman School	60
Milwaukee School of Languages	60
Alcott School	56
Milwaukee Spanish Immersion School	55
New School for Community Services	54
Milwaukee French Immersion School	51
Cooper School	49
Elm Creative Arts School	47
Milwaukee High School of the Arts	47
Honey Creek School	45
Ninety-Fifth Street School	45
Maryland Avenue Montessori School	45
King High School	45
Burdick School	43
Craig Montessori School	41
Meir School	40
Tippecanoe School	37
Milwaukee German Immersion School	32
Fernwood Montessori School	29

Key:	K-5	Middle
	K-6, K-8, Emerging K-8	Middle-High
	K-12	High

Appendix D

Milwaukee County Medicaid pediatric dental providers*

Dental center	Dentist(s)	Address	Phone	Wait time
American Dental Group	Drs. Syed, Chaudhry	6719 W. Capitol Dr., Milwaukee, WI 53216	(414) 464-6300	4 months
Children's Dental Center, Downtown	Drs. Shea, Studders	1020 N. 12th St., 5th floor, Milwaukee, WI 53233	(414) 277-8960	4 months
Children's Dental Center, Hospital	Drs. Barbeau, Post, Shea, Studders	9000 W. Wisconsin Ave., Milwaukee, WI 53204	(414) 607-5280	4 months
Cudahy Dental Associates S.C.	Dr. Austermann	6217 S. Packard Ave., Cudahy, WI 53110	(414) 764-5550	Variable
Robert Deboer, D.D.S	Dr. Deboer	152 W. Wisconsin Ave. #212, Milwaukee, WI 53208	(414) 271-1166	1 1/2 months
Dobak Dental	Dr. Dobak	5535 S. 108th St., Hales Corners, WI 53130	(414) 529-4015	2 weeks
Family Dental Center	Dr. Ciepluch	3500 W. Lisbon Ave., Milwaukee, WI 53208	(414) 342-0378	3 months
William Fink, D.D.S.	Dr. Fink	505 W. Mitchell St., Milwaukee, WI 53204	(414) 383-3200	3 weeks
Jerry D. Gragg, D.D.S.	Dr. Gragg	3489 N. 76th St., Milwaukee, WI 53222	(414) 445-4111	2-3 months
Guadalupe Dental Clinic	Drs. Schmidt, Gragg	1112 S. 3rd St., Milwaukee, WI 53204	(414) 643-8787	2 weeks
M.A.T.C	Drs. Napp, Olsen, Newman, Santilli	700 W. Highland Ave., Milwaukee, WI 53233	(414) 297-6573	Walk-in
Madre Angela Dental Clinic	Staff and volunteer dentists	1308 S. Caesar Chavez Dr., Milwaukee, WI 53204	(414) 383-3220	Walk-in & urgent care
Marquette University Dental Clinic	Drs. Creamer, Hodgson	1801 W. Wisconsin Ave., Milwaukee, WI 53233	(414) 288-7273 (414) 288-6790	15-90 days
Mid City Dental Group	Dr. Celestino Perez	6815 W. Capitol Dr., #200, Milwaukee, WI 53216	(414) 445-4111	6-8 weeks
Milwaukee Heritage Health Center (MLK)	Drs. Le, Martin, Dacosta, Robinson	2556 N. MLK Dr., Milwaukee, WI 53212	(414) 372-8080	4 weeks
Northtown Dental Group	Dr. Mack	1929 W. Atkinson Ave., Milwaukee, WI 53206	(414) 442-4690	6 weeks
Azim Presswala, D.D.S	Dr. Presswala	4359 S. Howell Ave. #304, Milwaukee, WI 53207	(414) 489-7648	3-6 months
Progressive Pediatric Dentists, S.C.	Drs. Shea, Chybowski	331 E. Puetz Rd., #106, Oak Creek, WI 53154	(414) 768-1020	1 week morning appt.
Smith Dental	Drs. Guevara, Burt, Bittner	3520 W. Oklahoma Ave., Milwaukee, WI 53215	(414) 671-4990	Waiting list, 3-4 months
Westside Health Center	Dr. Morris	3522 W. Lisbon Ave., Milwaukee, WI 53208	(414) 934-9466	2 weeks
Wisconsin Orthodontic Specialists	Dr. Machi	3044 S. 92nd St., West Allis, WI 53227	(414) 327-2250	4 weeks

Prepared by: Drs Alexandria Saulsberry and Sima Patel, Children's Hospital and Health System, Children's Research Institute and the Medical College of Wisconsin Community Pediatrics Training Initiative.

Appendix D cont.

Milwaukee County Medicaid pediatric dental providers* cont.

Tips for parents	Age of child	Straight T19	SEDA	Doral (contract expires 8/31/07)	Uninsured
Call anytime	≥ 3 years	x	x	x	
See special needs children	≥ Birth	x		x	
See special needs children	≥ Birth	x		x	
Call anytime	First tooth - 14 years	x			
Call anytime	≥ 3 years	x	x	x	
Call anytime	≥ 5 years	x	x		
Call anytime	≥ 3 years	x	x		
Call anytime	≥ Birth	x	x		
Call anytime	≥ 4 years	x	x	x	
Call before coming with emergency	3 years unless emergency	x			Sliding fee
Basic dental services only	≥ Birth				Child cleaning \$3
Picture ID & proof of monthly income if applicable	≥ Birth				Free if qualify
Basic & urgent services	≥ 1 year	x	x	x	Sliding fee
Call last week of month for appt.	> 3 years	x	x	x	
Call first week of the month for appt.	≥ 18 months emergency, ≥ 3 years routine	x	x	x	Sliding fee
Call anytime	≥ 6 years	x		x	
Call anytime	≥ 6 years	x	x		
Longer wait for after-school appts.	≥ 2 years, younger if problems	x			
Call anytime	≥ 2 years	x	x		
New patients call at 8 a.m., or walk-in is better	≥ 3 years	x	x	x	x
Call anytime	≥ 9 years	x	x	x	

*Providers accepting new pediatric Medicaid patients as of February, 2007.

Appendix E

Inventory of current oral health services and programs serving children in Milwaukee

Institution	Children served (annually)	Scope-of-services
Bruce Guadalupe School Clinic	<ul style="list-style-type: none"> Individual children: n/a Ages: 3-14 years 	<ul style="list-style-type: none"> Provider: 1 hygienist Dental chair: 1 Screening: ongoing Preventive: cleanings, fluoride varnish, sealants Treatment/restorative: refers to Madre Angela Dental Clinic
Children's Hospital of Wisconsin (CHW) Dental Centers	<ul style="list-style-type: none"> Individual children: 9,517* Ages: 0-18 years 	<ul style="list-style-type: none"> Providers: 4 pediatric dentists, 3 hygienists, 8 pediatric dental residents Dental chairs: 8 downtown, 13 CHW main campus Screening: ongoing Preventive: cleanings, fluoride varnish, sealants Treatment/restorative: as needed, offer sedation and orthodontics
Head Start, Milwaukee Public Schools (MPS)	<ul style="list-style-type: none"> Individual children: 170* Ages: 3-5 years 	<ul style="list-style-type: none"> Providers: volunteer Dental chairs: n/a Screening: annual day Preventive: fluoride varnish at Madre Angela Dental Clinic Treatment/restorative: refers to Madre Angela Dental Clinic
Head Start, Social Development Commission (SDC)	<ul style="list-style-type: none"> Individual children: 280* Ages: 3-5 years 	<ul style="list-style-type: none"> Providers: volunteer Dental chairs: n/a Screening: annual day Preventive: fluoride varnish by MATC Treatment/restorative: refers to MUSoD
Madre Angela Dental Clinic Columbia St. Mary's	<ul style="list-style-type: none"> Individual children: 491* (clinic) Ages: 0-18 years Individual children: 2,364* (school-based) Ages: 5-14 years 	<ul style="list-style-type: none"> Providers: volunteer and paid part-time staff Dental chairs: 8 Screening: ongoing Preventive: cleanings, fluoride varnish, sealants Treatment/restorative: as needed
Marquette University School of Dentistry (MUSoD)	<ul style="list-style-type: none"> Individual children: 3,127* Ages: 3-18 years 	<ul style="list-style-type: none"> Providers: 80 dental students Dental chairs: 167 Screening: ongoing Preventive: cleanings, fluoride varnish, sealants Treatment/restorative: as needed
Milwaukee Area Technical College (MATC) Dental Hygiene Clinic	<ul style="list-style-type: none"> Individual children: n/a Total patients (0-99): 1,600 Ages: 3-18 years 	<ul style="list-style-type: none"> Providers: 6-20 dental hygiene students Dental chairs: 30 Screening: ongoing Preventive: cleanings, fluoride varnish, sealants Treatment/restorative: refers to MUSoD and Madre Angela Dental Clinic
Milwaukee Health Services Inc.	<ul style="list-style-type: none"> Individual children: 1,097* Ages: 0-18 years 	<ul style="list-style-type: none"> Providers: 4 dentists, 1 hygienist Dental chairs: 7 Screening: ongoing Preventive: cleanings, fluoride varnish, sealants Treatment/restorative: as needed
Sixteenth Street Community Health Center	<ul style="list-style-type: none"> Individual children: n/a Total patients (0-99): 8,964^ Ages: 0-18 years 	<ul style="list-style-type: none"> No direct dental services Medical staff does apply fluoride varnish Subcontracts with Dental Associates, LTD for uninsured patients
Westside Healthcare Association	<ul style="list-style-type: none"> Individual children: 1,024* Ages: 0-18 years 	<ul style="list-style-type: none"> Providers: 1 dentist, 4 hygienists Dental chairs: 4 Screening: Head Start and ongoing Preventive: cleanings, fluoride varnish, sealants Treatment/restorative: as needed

^2005, *2006

Appendix E cont.

Inventory of current oral health services and programs serving children in Milwaukee cont.

Insurance	Outreach activities	Future directions
<ul style="list-style-type: none"> • Medicaid • Uninsured 	<ul style="list-style-type: none"> • Provides oral health education to parents, students and educators. • Partners with MATC for sealants. 	<ul style="list-style-type: none"> • Expansion of services offered and pursue increased programming on-site.
<ul style="list-style-type: none"> • Medicaid • Commercial 	<ul style="list-style-type: none"> • The ClearPath program participants are guaranteed an appointment within 6 weeks. 	<ul style="list-style-type: none"> • Potentially provide dental services at Next Door Foundation.
<ul style="list-style-type: none"> • Medicaid • Uninsured 	<ul style="list-style-type: none"> • Provides oral health education to Head Start parents, children and educators. 	<ul style="list-style-type: none"> • Partner with Milwaukee Area Health Education Center to provide extensive oral health education (fluoride varnish, nutrition) to teachers.
<ul style="list-style-type: none"> • Medicaid • Uninsured 	<ul style="list-style-type: none"> • Provides oral health education to Head Start parents, children and educators. • The Adopt-a-School program consists of a volunteer pediatric dentist who provides oral health screenings and fluoride applications. 	<ul style="list-style-type: none"> • Pursue additional funding to continue fluoride varnish.
<ul style="list-style-type: none"> • Uninsured • At or below 200% of the federal poverty level 	<ul style="list-style-type: none"> • Three mobile school-based teams (RDH and assistant) provide complete preventive care in 20 schools. • Provides dental services for Milwaukee Health Care for the Homeless (FQHC). 	<ul style="list-style-type: none"> • Expand mobile school-based oral health program teams.
<ul style="list-style-type: none"> • Medicaid • Uninsured (sliding fee) 	<ul style="list-style-type: none"> • Mobile sealant program through MPS. Screens (2,000 children ages 5-14) & applies sealants (1,100 children ages 5-14). • Monthly, Head Start screenings (Sept-May). • Assist in Head Start screening day and Milwaukee Give Kids a Smile Day. 	<ul style="list-style-type: none"> • Will re-open Johnson Clinic (Southside). • Identify new location to replace Coggs Clinic (Northside).
<ul style="list-style-type: none"> • Medicaid • Uninsured (sliding fee) 	<ul style="list-style-type: none"> • Participates in sealant programs at 2 MPS (Bruce Guadalupe & Windlake). • Partners with West Allis Health Department's SAS. • Assist in Head Start screening day and Milwaukee Give Kids a Smile Day. 	<ul style="list-style-type: none"> • Continue outreach sealant and fluoride varnish programs.
<ul style="list-style-type: none"> • Medicaid • Uninsured • Commercial 	<ul style="list-style-type: none"> • Integrating oral health into primary health care program. • Community oral health education. 	<ul style="list-style-type: none"> • Expand at new Silver Spring clinic.
<ul style="list-style-type: none"> • Medicaid referred to HMO providers • Uninsured referred to Dental Associates, LTD (subcontract) • Commercial 	<ul style="list-style-type: none"> • Community oral health education. 	<ul style="list-style-type: none"> • Continue referral program with private dental offices.
<ul style="list-style-type: none"> • Medicaid • Uninsured • Commercial 	<ul style="list-style-type: none"> • Head Start screenings. • Community oral health education. 	<ul style="list-style-type: none"> • Expansion of current facilities.

Appendix F

City of Milwaukee Medicaid utilization (2006)

Procedure code	Recipients 0-6 years	Recipients 7-12 years	Recipients 13-17 years	Total recipients
	(50,989 eligible)	(33,326 eligible)	(26,672 eligible)	(110,987 eligible)
D0120 - Periodic oral exam*	2,755	4,659	2,230	9,644
D0140 - Limited oral evaluation*	682	570	603	1,855
D0150 - Comprehensive oral exam*	3,637	2,921	2,141	8,699
D0210 - Intraoral complete series (incl. bitewings)	391	1,317	1,339	3,047
D0220 - Intraoral - first periapical film	2,351	2,100	1,260	5,711
D0230 - Intraoral - each add'l periapical film	1,429	1,170	616	3,215
D0272 - Bitewings - two films	3,231	4,289	1,219	8,739
D0274 - Bitewings - four films	96	78	1,422	1,596
D0330 - Panoramic film	204	1,231	1,052	2,487
D1110 - Prophylaxis - adult 13-99**	17	215	4,096	4,328
D1120 - Prophylaxis - child 0-12**	1,730	1,882	33	3,645
D1351 - Sealant, per tooth	624	1,921	632	3,177
D2140 - Amalgum - one surface prim. or perm.	496	773	875	2,144
D2150 - Amalgum - two surface prim. or perm.	626	952	823	2,401
D2160 - Amalgum - three surface prim. or perm.	189	225	372	786
D2331 - Resin - two surface prim. or perm.	111	66	55	232
D2930 - Prefab. stainless steel crown - prim. tooth	852	325	0	1,177
D3220 - Removal of tooth pulp***	672	265	5	942
D3310 - Anterior endodontic therapy***	0	19	40	59
D7140 - Extraction, single tooth***	997	1,521	392	2,910

*Exams - 20,198

**Prophys - 7,973

***Urgent care - 3,911

Source: Wisconsin Medicaid, April 2007.

Appendix G

Fee schedule comparison

Procedure code	Wisconsin Medicaid	Private approved (average)	Private paid (average)	ADA 75th regional percentile*
D0120 - Periodic oral exam	\$16.00	\$32.00	\$26.00	\$36.00
D0140 - Limited oral evaluation	\$20.00	\$47.00	\$38.00	\$55.00
D0150 - Comprehensive oral exam	\$21.00	\$49.00	\$39.00	\$57.00
D0210 - Intraoral complete series (incl. bitewings)	\$46.00	\$104.00	\$80.00	\$98.00
D0220 - Intraoral - first periapical film	\$8.00	\$19.00	\$16.00	\$21.00
D0230 - Intraoral - each add'l periapical film	\$6.00	\$14.00	\$12.00	\$18.00
D0272 - Bitewings - two films	\$13.00	\$30.00	\$26.00	\$33.00
D0274 - Bitewings - four films	\$18.00	\$39.00	\$31.00	\$46.00
D0330 - Panoramic film	\$40.00	\$56.00	\$42.00	\$90.00
D1110 - Prophylaxis - adult 13-99	\$28.00	\$60.00	\$49.00	\$66.00
D1120 - Prophylaxis - child 0-12	\$22.00	\$44.00	\$38.00	\$49.00
D1351 - Sealant, per tooth	\$17.00	\$36.00	\$20.00	\$39.00
D2140 - Amalgum - one surface prim. or perm.	\$35.00	\$87.00	\$54.00	\$93.00
D2150 - Amalgum - two surface prim. or perm.	\$45.00	\$108.00	\$70.00	\$117.00
D2160 - Amalgum - three surface prim. or perm.	\$56.00	\$128.00	\$84.00	\$140.00
D2331 - Resin - two surface prim. or perm.	\$52.00	\$125.00	\$77.00	\$140.00
D2930 - Prefab. stainless steel crown - prim. tooth	\$87.00	\$197.00	\$124.00	\$231.00
D3220 - Removal of tooth pulp	\$48.00	\$117.00	\$65.00	\$150.00
D7140 - Extraction, single tooth	\$42.00	\$98.00	\$57.00	\$119.00
D3220 - Removal of tooth pulp	\$48.00	\$117.00	\$65.00	\$150.00
D7140 - Extraction, single tooth	\$42.00	\$98.00	\$57.00	\$119.00

*Refers to American Dental Association (ADA) East North Central Region.

Notes

Healthy Teeth = Healthy Kids

2007

Healthy Teeth = Healthy Kids

A plan to improve the oral health of Milwaukee children.

A partnership of:

Children's Health Alliance of Wisconsin

Children's Hospital of Wisconsin Dental Center

Marquette University School of Dentistry

Medical College of Wisconsin

Milwaukee Public Schools

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